

# RESEARCH INQUIRY | WALSH LAB

To most quickly inquire about our research, you may print out this form and complete it fully. Please submit this form via a method noted below. You may call 617-919-4795 to check the status if you do not receive a call within a week to ensure it was received. To speed up the screening process you may also wish to complete and submit the provided clinical history summary and family history forms with this inquiry.

Mail: Walsh Lab Study Inquiry | 300 Longwood Avenue, BCH 3150 | Boston, MA 02115

Fax: 617-919-2300

Email: walshresearch@childrens.harvard.edu

## Patient Information

Patient's Name: \_\_\_\_\_ Date form submitted: \_\_\_\_\_

Gender (circle): Male      Female      Current Age: \_\_\_\_\_      Date of Birth: \_\_\_\_\_

Referred by: \_\_\_\_\_  
Health Care Provider Name    Hospital Affiliation    Office Phone Number

## Name and Contact Information for Person Completing Form/Making Inquiry

Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Phone (Please circle preferred number):

Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
\_\_\_\_\_

Email Address: \_\_\_\_\_

## Patient Symptoms (please complete the separate clinical history summary to provide more details)

Brain MRI structural abnormality      NO      YES → Type: \_\_\_\_\_ Age diagnosed \_\_\_\_\_

Seizures      NO      YES → Type: \_\_\_\_\_ Age diagnosed \_\_\_\_\_

Other: \_\_\_\_\_  
\_\_\_\_\_

### *For Walsh Lab use only:*

Inquiry Form Rc'd via:      Fax      Email      Post      Date Inquiry Rc'd: \_\_\_\_\_

Screening Forms Rc'd: \_\_\_\_\_      Inquiry Logged by/date: \_\_\_\_\_

Submitter Notified date: \_\_\_\_\_      Coordinating GC: \_\_\_\_\_